Supreme Court, U.S.
FILED
981455 FEB 22 1999
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No. _____

In the Supreme Court

of the United States

TERM: OCTOBER, 1998

JANICE BIAMONT,
Petitioner,
v.
SAIF CORPORATION, PACIFIC SEAFOOD and OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE OREGON COURT OF APPEALS
AND OREGON SUPREME COURT

PETITION FOR WRIT OF CERTIORARI

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February 22, 1999.

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QUESTIONS PRESENTED

The Oregon's Workers' Compensation Act provides that injured worker's are entitled to benefits for medical care related to their compensable injury unless the state finds that the care is "excessive, inappropriate or ineffectual." Oregon Revised Statute (ORS) 656.245; ORS 656.327. When benefits are denied on that basis, the determination is made by submission of the record to a medical reviewer, who has 60 days to make proposed findings. The worker may then request review at what the statute calls a "contested case hearing." However, the Administrative Law Judge (ALJ) conducting this hearing must adopt the findings from the medical review unless they are not supported by substantial evidence or are contrary to law. ORS 656.327(2)

The question presented for review is whether the Due Process clause of the Fourteenth Amendment permits a state to deny medical benefits that are otherwise guaranteed by statute without ever providing a true evidentiary hearing.

PARTIES TO THE PROCEEDINGS IN THE COURT BELOW

The petitioner, Janice Biamont, was a petitioner before the Oregon Court of Appeals and Oregon Supreme Court. SAIF Corporation, Pacific Seafood and the Oregon Department of Consumer and Business Services were respondents in those proceeding.

The Oregon Supreme Court case number was S45796. The Court of Appeals case number was A97380. The case number for the administrative agency decision was H96-217.

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IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1998

JANICE BIAMONT, *Petitioner,*

v.

SAIF CORPORATION, PACIFIC SEAFOOD and OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE OREGON COURT OF APPEALS AND OREGON SUPREME COURT

The petitioner, Janice Biamont, respectfully petitions for a writ of certiorari to issue to review the judgment of the Oregon Court of Appeals, entered in this case on August 12, 1998, petition for review to the Oregon Supreme Court denied on November 24, 1998.

OPINIONS BELOW

Neither Oregon Court issued a written opinion. The judgment of the Court of Appeals affirming without opinion is reprinted in Appendix A hereto. The Order of the Supreme Court denying review is reprinted in Appendix C hereto.

BEST AVAILABLE COPY

The Final Order of the Oregon Department of Consumer and Business Services is not reported. It is reprinted in Appendix B hereto.

JURISDICTION.

(1) The Decision of the Oregon Supreme Court denying discretionary review was entered on November 24, 1998.

(2) The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

STATUTORY PROVISIONS INVOLVED

This appeal involves Oregon Revised Statute (ORS) 656.327 (set forth in Appendix D) and the Fourteenth Amendment to the United States Constitution, which provides in pertinent part:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law;

STATEMENT OF THE CASE

Petitioner, Biamont, suffered a work related injury. SAIF (State Accident Insurance Fund) agreed that Biamont's compensable conditions included "cervical condition with nerve root involvement caused by the 8/28/93 industrial injury, for which a diagnosis will be better defined

by claimant's attending physician after further testing." After further testing, Biamont's treating physician determined that the source of her cervical condition was a disc herniation at the C6-7 vertebral level, for which he recommened and performed a discectomy. SAIF withheld payment and petitioned the Medical Review Unit of the Oregon Department of Consumer and Business Services for an order that it would not be responsible for payment for this surgical procedure because the procedure was "inappropriate."

This case involves the application of the Due Process Clause of the Fourteenth Amendment to Oregon Revised Statute 656.327, which specifies the process to be followed when an injured worker is denied medical benefits, to determine whether that statutory process satisfies the demands of due process.

Pursuant to the statutory procedure, an RN with the Medical Review Unit reviewed the medical records without conducting a hearing. These records included reports from doctors who did not believe that the surgery would help Biamont's condition as well as reports from Biamont's physician that the surgery was necessary and that Biamont reported significant improvement following the surgery. (App. B-7-8). The Review Unit issued a Proposed and Final Order, concluding that the surgery was not appropriate treatment. Another RN reconsidered the medical records and issued an order affirming the proposed and final order. Biamont was then allowed a telephone hearing

before an administrative law judge. At the hearing, Biamont was limited to producing only medical evidence that supplemented, corrected or clarified existing evidence and dealt with her condition prior to the time the medical review unit completed its reconsideration. As required by statute, the ALJ adopted the proposed findings of the Medical Review Unit because they were supported by substantial evidence. Following written exceptions to the ALJ's proposed order, the Director of the Department of Consumer and Business Services issued a Final Order that Biamont would not receive medical benefits for the surgical procedure.

At hearing before the ALJ, Biamont contended that the review process violated due process: "[W]e feel that the – the claimant's right to due process, to confront the other parties or – is being pre – prevented, and that she is prevented from having adequate protection under the Constitution of U.S. and Oregon ...." (Tr. 2). The Department's Final Order addressed, but rejected, this argument: "[T]he director has held that ORS 656.327 is not unconstitutional because claimant has notice, a meaningful opportunity to participate and an informed and impartial decision maker. Thus, the statute is not unconstitutional." (App. B-11-12). Biamont did not present a constitutional challenge during the record review stage. Because that portion of the process is simply a review of medical records by medical personnel, there is no room to either consider or address constitutional questions.

Biamont appealed the administrative

decision to the Oregon Court of Appeals, which reviewed the decision under the provisions of ORS 656.327(2). That Court affirmed without opinion.

Biamont then petitioned for review in the Oregon Supreme Court, which has discretionary jurisdiction to review decisions of the Court of Appeals pursuant to ORS 2.520. The Oregon Supreme Court denied Biamont's petition for review.

Biamont brings her case before this Court noting jurisdiction pursuant to 28 U.S.C. § 1257(a)

REASONS FOR GRANTING THE PETITION

Petitioner seeks this Court's intervention to provide guidance to the states on the important question of whether they may, consistent with the demands of due process, deny protected medical benefits without ever providing an oral evidentiary hearing.

The State of Oregon has established a system of workers' compensation under which those injured during the course and scope of their employment have, as their exclusive remedy, medical and disability benefits payable pursuant to a comprehensive statutory scheme. Once it is determined that a worker suffers from a work related condition, the worker is guaranteed medical care to treat that condition, in the absence of an order that the medical care is "excessive, inappropriate or ineffectual." ORS 656.245; ORS 656.327. If the insurer seeks such

an order, the obligation to pay the medical bills is suspended, and the workers' entitlement to have the benefits reinstated is determined through an administrative "paper" review of the medical records. ORS 656.327. Following this determination, the worker is permitted an oral "hearing" at which the findings of the medical review must be accepted if they are supported by substantial evidence in the record. ORS 656.327(2).

This case raises an important federal question that affects every state and that the Third Circuit has addressed in a manner contrary to that of Oregon courts.

I. The administrative review process utilized by the state deprives injured workers of a protected property interest without due process of law.

The Oregon Workers' Compensation Act is a mandatory statutory system of compensation for work place injuries. The Act requires that every employer employing more than one subject worker[1] must maintain assurance with the Oregon Department of Consumer and Business Services that its subject workers will receive the mandated benefits for compensable injuries. ORS 656.017; ORS 656.023. In exchange, every employer who

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[1] Every worker in the state is considered a subject worker except for a limited class of exempt workers, such as partners and sole proprietors, interstate transportation workers and private domestic workers. ORS 656.027.

maintains the necessary insurance coverage is immune from all other liability arising out of injuries during the course of employment. ORS 656.018. There is no provision for workers to "opt out" of this system.

Pursuant to the statutory framework, a worker who has incurred a "disabling compensable injury" is statutorily entitled to medical services to treat that injury. ORS 656.245. Pursuant to state administrative rules, the insurer has only 45 days to pay medical bills incurred by the injured worker, and can be penalized for failing to meet this deadline, Oregon Administrative Rule (OAR) 436-009-0030(2)(a); OAR 436-060-0155. However, insurers may avoid this obligation by obtaining a determination from the Department of Consumer and Business Services that the medical care is "excessive, inappropriate or ineffectual." ORS 656.327 provides, in pertinent part:

> "(1)(a) If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request

review of the treatment by the director and so notify the parties.

...

"(2) The director shall review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to perform reasonable and appropriate tests, other than invasive tests, upon the worker and may examine the worker. Notwithstanding ORS 656.325 (1), the worker may refuse a test without sanction. Review of the medical treatment shall be completed and the director shall issue an order within 60 days of the request for review. The director shall create a documentary record sufficient for purposes of judicial review. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request a contested case hearing before the director pursuant to ORS 183.310 to 183.550. At the contested case hearing, the administrative order may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues shall be admitted. If the director issues an order declaring

> medical treatment to be not compensable, the worker is not obligated to pay for such treatment. Review of the director's order shall be by the Court of Appeals pursuant to ORS 183.310 to 183.550.

The process by which Biamont was denied medical benefits to pay for the surgery her doctor recommended constituted state action that deprived her of a protected property interest. As such, it should have complied with the requirements of the Fourteenth Amendment.

A. The denial of benefits constituted state action.

SAIF, the State Accident Insurance Fund, sought permission from the Oregon Department of Consumer and business services to deny medical benefits to Biamont. SAIF was a state actor, and its utilization of state procedures to escape payment for medical benefits constituted state action. As this Court held in National Collegiate Athletic Ass'n v. Tarkanian, 188 U.S. 179, 192, 109 S.Ct. 454, 102 L.Ed.2d 469 (1988), state action may be found "if the State creates the legal framework governing the conduct, if it delegates its authority to a private actor, or sometimes if it knowingly accepts the benefits derived from unconstitutional behavior." (Citations omitted.) The state action inquiry has two components: "first whether the claimed constitutional deprivation resulted from the exercising of a right or privilege having its source in state authority"

and "second, whether the private party charged with the deprivation could be described in fairness as a state actor." Edmonson v. Leesville Concrete Co., Inc., 500 U.S. 614, 620, 111 S.Ct. 2077, 114 L.Ed.2d 660 (1991). Both the right to medical benefits and the process for denying medical benefits are created by the state.

SAIF is a state actor. SAIF was created by the Oregon legislature for the purpose of transacting workers' compensation insurance and reinsurance; among its powers is the power to provide workers' compensation insurance to Oregon employers to the same extent as a private insurer. ORS 656.752(1). The state has authorized the methods by which SAIF will calculate and charge premiums to those employers it insures and has specified SAIF's ability to assess penalties and charge interest for late payment. ORS 656.504; ORS 656.505; ORS 656.508; ORS 656.552; ORS 656.560. All moneys paid to the State Accident Insurance Fund are transfered to the State Treasurer and deposited in the Industrial Accident Fund, a trust fund maintained exclusively for the purpose of the Workers' Compensation Act. ORS 656.632; ORS 656.634; Alsea Veneer, Inc. v. State of Oregon, 318 Or. 33, 42-43, 862 P.2d 95, 99 (1993). SAIF is a state actor.

Regardless of SAIF's unique status as a creature of statute, any insurer invoking the state's procedure for denying benefits should be considered a state actor. In Edmonson, this Court held that, in determining whether a private litigant could be deemed a state actor, it is appropriate to

examine 1) "the extent to which the actor relies on governmental assistance and benefits"; 2) "whether the actor is performing a traditional governmental function"; and 3) "whether the injury caused is aggravated in a unique way by the incidents of governmental authority." 500 U.S. at 621-22. As this Court concluded in Edmonson, weighing all of the various factors, private litigants could fairly be said to be state actors when exercising the peremptory challenges granted by the state.

Similarly, private insurers can fairly be said to be state actors when they utilize the procedures provided by the state for escaping the statutory obligation to pay medical benefits. The medical dispute resolution process and the workers' compensation system of which it is a part would not exist "without the overt, significant participation of the government." See Edmonson, 500 U.S. at 622. Workers' compensation insurers in Oregon have no authority to permanently deny medical benefits without the approval of the agency charged with administering the Act. ORS 656.327(1). Thus, the state is intimately involved in the denial of medical benefits. The denial process constitutes state action regardless of whether it is utilized by SAIF or by a private insurer. See Tulsa Professional Collection Services v. Pope, 485 US 478, 487, 108 SCt 1340, 99 LEd2d 565 (1988) ("When private parties make use of state procedures with the overt, significant assistance of state officials, state action may be found."); Flagg Brothers, Inc. v. Brooks, 436 U.S. 149, 157, 98 S.Ct. 1729, 56 L.Ed.2d 185 (1978) (If the

government is overtly involved in a private deprivation of protected property rights, then the Fourteenth Amendment applies.)

B. Biamont has a protected property interest in the medical benefits.

The medical benefits that SAIF and the Director denied to Biamont are a protected property interest. As this Court explained in Board of Regents v. Roth, 408 U.S. 564, 569, 92 S.Ct. 2701, 2705, 33 L.Ed.2d 548 (1972):

> To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead, have a legitimate claim of entitlement to it. ...
>
> Property interests, of course, are not created by the Constitution. Rather, they are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law--rules or understandings that secure certain benefits and that support claims of entitlement to those benefits. ...

408 U.S. at 577. Using this analysis, this Court has held that recipients have a protected property interest in Social Security

disability benefits, Matthews v. Eldridge, 424 U.S. 319, 96 S.Ct. 893, 47 L.Ed 2d 18 (1976), and welfare benefits, Goldberg v. Kelly, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1970), because the recipients' claims of entitlement to the benefits were grounded in the statutes defining eligibility for them.

Similarly, state law has created for every Oregon worker a claim of entitlement to medical care to treat a disabling compensable injury. ORS 656.245. The state requires all Oregon employers to provide these benefits for their subject workers. Workers' compensation benefits have been deemed by Oregon courts to be a property interest to which due process protections attach. Carr v. SAIF, 65 Or App 110, 118, 670 P2d. 1037 (1983). (Worker's entitlement to temporary disability benefits is a protected property interest because the entitlement derives from the requirements of state law.) That Biamont has a protected property interest in her medical benefits was not seriously contested below.

C. Greater process is due.

The Fourteenth Amendment requires, at a minimum, the basic elements of notice and a **meaningful** opportunity to be heard. Brock v. Roadway Exp., Inc., 481 U.S. 252, 261, 107 S.Ct. 1740, 95 L.Ed.2d 239 (1987); Logan v. Zimmerman Brush Co., 455 U.S. 422, 429, 102 S.Ct. 1148, 71 L.Ed.2d 265 (1982); Mullane v. Central Hanover Bank & Trust Co., 339 U.S. 306, 313, 70 S.Ct. 652, 94 L.Ed. 865 (1950). When adjudicative facts are at

issue, the party affected is entitled to know and meet unfavorable evidence with the weapons of rebuttal evidence, cross-examination and argument. Peters v. Hobby, 349 U.S. 331, 75 S.Ct. 790, 99 L.Ed. 1129 (1955); Vitek v. Jones, 445 U.S. 480, 100 S.Ct. 1254, 63 L.Ed.2d 552 (1980).

Those minimum procedural requirements are a matter of federal law and cannot be diminished by the fact the state has specified different procedures that it deems adequate. Cleveland Bd. of Educ. V. Loudermill, 470 U.S. 532, 541, 105 S.Ct. 1487, 84 L.Ed.2d 494 (1985). The procedure established by the legislature in ORS 656.327 fails to satisfy even the minimum procedural protections that the Due Process Clause of the Fourteenth Amendment guarantees.

This Court has explained that due process is a flexible concept that "calls for such procedural protections as the particular situation demands." Matthews, 424 U.S. at 334. The amount of process constitutionally due is determined through a balancing of several factors: 1) the private interest that will be affected by the official action, 2) the risk of erroneous deprivation of that interest through the existing procedures, and 3) the government's interest. Matthews, 424 U.S. at 335.

On numerous occasions, this Court has undertaken to define the amount of process due prior to depriving an individual of a protected property interest. With the exception of Goldberg, this Court has generally held that something short of an oral, evidentiary hearing with the right to

confront witnesses is sufficient pre-termination. See Brock, 481 U.S. at 263; Matthews, 424 U.S. at 333. However, those decisions often hinged on the availability of a full evidentiary hearing post-termination. See, e.g., Brock, 481 U.S. at 263 ("So long as the prereinstatement procedures establish a reliable 'initial check against mistaken decisions,' ... and complete and expeditious review is available, the preliminary reinstatement provisions ... fairly balance the competing interests ...."); Loudermill, 470 U.S. at 546. Indeed, this Court has explained that failure to provide a full evidentiary hearing soon enough after the suspension of benefits can deny individuals a meaningful opportunity to be heard and become a constitutional violation. Brock, 481 U.S. 424 U.S. at 267; Loudermill, 470 U.S. at 547; Barry v. Batchi, 443 U.S. 55, 64, 99 S.Ct. 2642, 61 L.Ed.2d 365 (1979); Matthews, 424 U.S. at 341-42.

Here, it is not simply that injured workers are denied the protection of some review pre-termination; Oregon workers are never provided a meaningful opportunity to be heard. There is no requirement that a preliminary evaluation be made before the date on which medical benefits would otherwise be due and payable. Then, the primary decision to deny benefits is made without any opportunity for the claimant to be heard in person, to present testimony of witnesses or to cross-examine adverse witnesses. It is made merely on the basis of "medical information and records." The state permits the Department 60 days to complete this process. ORS 656.327(2). Although the worker is ultimately provided a so-

called "contested case hearing," this is not an evidentiary hearing. The statute prohibits the introduction of "new medical evidence" at the hearing.[2]

The most significant flaw in the "contested case hearing" is that it can produce no independent findings. The administrative law judge is constrained to accept the earlier findings unless it can be said that those findings are not supported by substantial evidence or are contrary to law. ORS 656.327(2). Given Oregon's approach to the substantial evidence rule, this opportunity to be heard is essentially meaningless. Oregon courts have repeatedly explained that "in the context which is likely frequently to occur in workers' compensation cases, if there are doctors on both sides of a medical issue, whichever way the [director] finds the facts will probably have substantial evidentiary support." Queener v. United Employers Ins., 113 Or. App. 364, 832 P.2d 1265 (1992) (Quoting Armstrong v. Asten-Hill, 90 Or.App. 200, 206, 752 P.2d 312 (1988)). If there is a single medical opinion supporting a denial of benefits, there is almost no evidence a worker could conceivably present at the "hearing" that could lead to a result any different from the result

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[2] The agency has, perhaps, ameliorated this prohibition to some extent through promulgation of an administrative rule that permits additional evidence if it "supplements, corrects or clarifies existing records and deals with events occurring before the Director's record closed." OAR 436-001-0195(2). Two of the medical records that Biamont attempted to submit at hearing were rejected on the basis that they addressed her condition after the record had closed. (App. B-4)

of the paper review. For all practical purposes, the "hearing" is simply a review process, from which no independent decision can emerge; Oregon workers are never provided an evidentiary hearing before their medical benefits are denied forever.

Applying the Matthews factors, the process for denying medical benefits to injured workers in Oregon is constitutionally insufficient. Claimant's interest in medical care is significant. If medical providers cannot be paid for treatment, few will be willing to provide the treatment that the workers need. Timely medical attention has been observed to be a "basic necessity of life." Memorial Hospital v. Maricopa County, 415 US 250, 259-261, 96 SCt 893, 47 LEd 2d 18 (1974). ("To allow a serious illness to go untreated until it requires emergency hospitalization is to subject the sufferer to the danger of a substantial and irrevocable deterioration in his health.")

The risk that a worker's benefits will be erroneously denied through the existing procedures is substantial. Petitioner is aware that this Court, in Matthews, declined to require a pre-deprivation oral evidentiary hearing because the issue turned upon "routine, standard, and unbiased medical reports by physician specialists." Matthews 424 U.S. at 344. That is not the case here. Although the issue is a medical one, the question of whether care is appropriate is inextricably bound to the factual question of whether the care improved the worker's condition.

That is an issue upon which the worker must be heard and her or his credibility assessed.

Finally, the state's interest in this matter is to avoid erroneous deprivation of the medical benefits it requires employers to provide. It would require no additional resources or time to allow the ALJ to make independent factual findings following the hearing. This change, alone would make substantial strides toward providing an actual evidentiary hearing. Thus, under the factors outlined in Matthews, the process Oregon provides is not sufficient.

II. This case presents an important question of federal constitutional law that has not been, but should be, settled by this Court.

The question of the due process demands for denying workers' compensation medical benefits has broad implications. All 50 states provide a system of medical compensation for injured workers. LARSON, The Law of Workmen's Compensation, Volume 2, §61.00 (1996). Although the issue of pre-deprivation process due has been addressed by this Court on a number of occasions, the question of whether a state may essentially eliminate any meaningful opportunity for an oral evidentiary hearing, with presentation of testimony and cross-examination of adverse witnesses, has not been addressed.

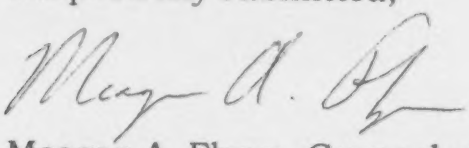
A similar issue has arisen recently out of the Pennsylvania workers' compensation system. Sullivan v. Barnett, 139 F.3d 158 (3d Cir.), cert.

granted, 119 S.Ct. 29 (1998). In Sullivan, the Third Circuit invalidated the aspect of Pennsylvania's workers' compensation law that allowed suspension of medical benefits without prior notice or meaningful opportunity to be heard. Pennsylvania allowed a full, *de novo* evidentiary hearing before benefits could be finally denied. Yet the Third Circuit still determined that the process as a whole was not sufficient to meet the demands of the Fourteenth Amendment. 139 F.3d at 176. The ruling that Oregon's more limited process is, nevertheless, constitutional is inconsistent with the Third Circuit's approach. This Court should address the conflict to provide necessary guidance to the states.

CONCLUSION

The petition for writ of Certiorari should be granted.

Respectfully submitted,



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Dated: February 22, 1999.

FILED: August 12, 1998

IN THE COURT OF APPEALS
OF THE STATE OF OREGON

JANICE C. BIAMONT,	)	
	)	
Petitioner,	)	DCBS No. H96-217
	)	
v.	)	CA A97380
	)	
PACIFIC SEAFOOD, SAIF CORPORATION and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES,	)	
	)	
Respondents.	)	

Date argued or submitted on briefs: July 9, 1998

Before: Warren, Presideing Judge, and Edmonds and Armstrong, Judges

Attorney for Petitioner: David A. Hytowitz

Attorney for Respondents pacific Seafood and SAIF Corporation: David L. Runner

Attorney for Respondent Department of Consumer and Business Services: Mary H. Williams

AFFIRMED WITHOUT OPINION

DESIGNATION OF PREVAILING PARTY AND AWARD OF COSTS

Prevailing party: Respondents

[X] No costs allowed.

Appellate Judgment
Effective Date: January 12, 1999

COURT OF APPEALS
(seal)

APPELLATE JUDGMENT

BEFORE THE DIRECTOR
DEPARTMENT OF CONSUMER
AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION

In the Matter of the Medical Treatment Dispute of	)	**FINAL ORDER**
	)	
	)	Contested Case No.:
JANICE C. BIAMONT, Claimant	)	H96-217
	)	Claim No.: 7771079E
	)	D/of Injury: 8/28/92
PACIFIC SEAFOOD, Employer	)	WCD File No.:
	)	G658749
SAIF CORPORATION, Insurer	)	Order No.: TX 96-084
	)	

On November 6, 1996, Hearings Judge Daina Upite conducted a telephone hearing. The petitioner was the claimant who was present and was represented by her attorney, David A. Hytowitz. The respondent was the employer, Pacific Seafood, and its insurer, SAIF Corporation (SAIF) which were represented by their attorney, James Booth. D. Kevin Carlson, Assistant Attorney General, represented the Workers Compensation Division (WCD).

On December 23, 1996, Judge Upite issued her order. On January 22, 1996, claimant timely filed exceptions to the December 23, 1996 order. SAIF filed its response to the exceptions February 11, 1997. Claimant filed her reply on February 20, 1997. 1 adopt the findings of facts and conclusion in Judge Upite's order which addressed the issues of whether WCD may be represented at a hearing and whether MRU's order was untimely. Having completed my review of the exceptions, I issue

this order.

ISSUES

1. Whether the procedures established by ORS 656.327 for resolution of medical treatment disputes are unconstitutional;

2. Whether the medical reviewer was practicing medicine without a license when she issued the administravie order in this treatment dispute;

3. Whether the administrative order of August 30, 1996, made legally sufficient findings of fact and conclusions of law;

4. Whether the administrative order of August 30, 1996, was supported by substantial evidence or contained an error of law; and

5. Whether the statutory prohibition on awards of attorneys' fees for services performed on behalf of claimant at the administrative review (*i.e.*, prior to the contested case level) is unconstitutional.

EVIDENTIARY RULING

Exhibits 1-133 were submitted by WCD. The insurer objected to the admission of Exhibits 119-122, 125, 127-130. These documents are exhibits which were submitted to MRU during its reconsideration of the May 15, 1996 order. The insurer contended that the reconsideration was improper and, therefore, documents admitted by MRU in the reconsideration process should

not have been admitted in this proceeding. However, because MRU was authorized to reconsider its own orders in its sole discretion (OAR 436-010-0008(l 1)(b)(B)), Judge Upite found that the reconsideration was proper. Therefore, it was also appropriate to admit the documents that were submitted to MRU as part of its reconsideration process, and the insurer's objections to those exhibits were overruled. Exhibits 1-133 were admitted in their entirety.

Claimant also submitted Exhibits P1-P41. Exhibits P5, P18, P23, P28, and P33 were withdrawn because they duplicated exhibits submitted by WCD. The insurer objected to the admission of Exhibits P35-P41 based on ORS 656.327(2), which provided that at the contested case hearing, no new medical evidence may be admitted. However, the director's rule, OAR 436-001-0195(2), provided that supplemental reports, corrections, and clarifications by medical professionals whose reports were in the medical evidence gathered by the director's staff were not considered "new medical evidence" prohibited by ORS 656.327(2), provided that these additional items dealt with events that occurred on or before the date the director's administrative record closed.

SAIF argued that OAR 436-001-0195(2) was inconsistent with ORS 656.327(2). However, as pointed out by claimant, the parties did not have the opportunity to respond to evidence presented by medical professionals or otherwise clarify medical evidence during the administrative procedure before MRU. The director's rule allows the parties a meaningful hearing by permitting them to fully present their medical evidence. At the same time, by restricting such additional evidence to supplementation, correction, and clarification dealing with events occurring before the director's

record closed, the rule enforces the prohibition against new medical evidence set forth in ORS 656.327(2). Thus, Judge Upite found that the director's rule was valid and applicable to this matter.

SAIF further argued that the record closed before the director on May 15, 1996, when the director's first order issued because the subsequent reconsideration was improper. However, as discussed above, the director may grant reconsideration in his sole discretion. Therefore, because the reconsideration was proper, Judge Upite concluded that the MRU record closed on August 30, 1996.

Based on the foregoing discussion, Exhibits P35-P39 were admitted. They all dealt with observations prior to the closure of the MRU record, and clarification of previously submitted medical opinions concerning evidence which was in the record before MRU. SAIF's objection to Exhibits P40-P41, however, was sustained. These exhibits clearly dealt with observations of claimant's condition after closure of the MRU record on August 30, 1996. Therefore, with the exception of the withdrawn exhibits discussed earlier, claimant's Exhibits P1 - P39 were admitted.

FINDINGS OF FACT

Claimant suffered compensable injuries on August 28, 1992, when she fell in a freezer, striking her right upper body, shoulder, and hip against a crate. Her claim was originally accepted for a right shoulder contusion. (Exhibit 7). Subsequently, SAIF accepted subacromial impingement syndrome of the right shoulder; a cervical condition with nerve root involvement, with the diagnosis to be better defined by claimant's attending physician after further testing; right L5

nerve root entrapment; and L4-5 disc bulge. (Exhibit 58).

In May 1993, John R. Mawk, M.D., performed a right L4-5 interspace exploration with foraminotomy. (Exhibits 40, 43). Approximately a month afterward, claimant reported to Eric W. Long, M.D., that she experienced gratifying relief of right lower extremity pain and numbness after this procedure, but she continued to have right shoulder problems. Dr. Long reported that claimant complained of puffiness, swelling, and a feeling of dullness in the right hand, as well as aching in the right forearm, but he noted that claimant had no convincing clinical or electromyographic evidence of right cervical radiculopathy. (Exhibit 43).

In September 1993, James B. Schader, M.D., performed a right shoulder arthroscopy and subacromial decompression. (Exhibit 49). Two months later, claimant reported "excellent resolution of deep right shoulder pain," but still reported considerable sensitivity in the right biceps tendon area. (Exhibit 53). Claimant complained more of tingling, pain and numbness in the right hand and forearm, and Dr. Long suspected "a little ulnar irritation at the right elbow." (Id.). On December 17, 1993, Dr. Long reported that claimant had been undergoing physical therapy and had good resolution of forearm and arm pain and numbness, but that she still had considerable sensitivity around her right shoulder. (Exhibit 57).

Dr. Schader concluded that claimant had developed adhesive capsulitis following her shoulder surgery, and on February 11, 1994, he performed right shoulder manipulation under general anesthesia. (Exhibits 59, 60).

Claimant continued to suffer right shoulder girdle pain

with limited motion, and on October 26, 1994, Dr. Schader performed arthroscopic distal clavicle excision in an effort to relieve her residual shoulder pain. (Exhibits 68, 71, 75). On February 16, 1995, Dr. Long reported that claimant was significantly improved compared with three months before. She was still having pain in the right upper trapezius and medial scapular areas, but did not have the diffuse periscapular pain which she had previously. She also no longer had diffuse numbness involving the entire right ulnar forearm and hand, as she had previously had, but she did have some numbness in the fingers of the right hand. Claimant had no significant left shoulder or left upper extremity pain. She remained concerned about right shoulder girdle pain and limited motion. Dr. Long ordered cervical imaging to determine whether claimant had a cervical disc or possible cervical root disease. (Exhibit 80).

The February 22, 1995 cervical MRI revealed a small, central annulus bulge or herniation at C5-6 and minimal annuli prominence at C6-7 and C7-TI. (Exhibit 81). When he examined claimant in May 1995, Dr. Long concluded that claimant had discogenic cervical pain, with the primary persisting symptom source being the cervical disc lesion at C5-6. (Exhibit 88).

On June 19, 1995, Dr. Mawk reported that claimant continued to have pain in her right arm and numbness in the medial two fingers of her right hand. She also had a head tilt of about 15 degrees to the right. (Exhibit 90). Dr. Mawk requested authorization for a cervical discectomy. (Exhibit 91).

In August 1995, Drs. Marble and Williams examined claimant at the insurer's request and concluded that the proposed cervical surgery was not appropriate. The examining

physicians felt that claimant's subjective complaints were not supported by objective findings, that she did not have objective findings of cervical radiculopathy, and that her MRI did not demonstrate a surgical lesion. (Exhibit 93).

Dr. Long examined claimant in September 1995 and felt that claimant definitely had discogenic cervical pain. He diagnosed "subtle residual clinical evidence of mild right C6 radiculopathy," but suspected that her symptoms were myelopathic rather than radicular. (Exhibit 95). Dr. Long concluded that claimant was an appropriate candidate for a C5-6 discectomy. (Exhibit 96).

In October 1995, the insurer requested director review of the appropriateness of cervical discectomy proposed by Dr. Mawk. (Exhibit 97).

On October 24, 1995, claimant had a repeat cervical MRI, ordered by Dr. Mawk, which revealed a small, central disc herniation at C6-7, increased in comparison with the February 1995 imaging. (Exhibit 100). Dr. Mawk felt the C6-7 herniation was somewhat eccentric to the left, and noted that claimant was developing some left upper extremity numbness and achiness in addition to her right-sided symptoms. (Ex. 102).

On December 11, 1995, neurosurgeon David J. Silver, M.D., examined claimant at the director's request regarding the appropriateness of the C5-6 discectomy and/or fusion proposed by Dr. Mawk. (Exhibit 105). Dr. Silver felt the surgery was not appropriate because claimant had no clinical evidence of cervical nerve root compression or objective evidence of a cervical discogenic syndrome at either the C5-6 or C6-7 levels. (Exhibit 105 at 6-7).

Dr. Long reviewed Dr. Silver's report and responded that claimant's symptoms were more consistent with a mild right cervical myelopathy rather than a cervical radiculopathy, and that without surgical decompression, the cervical myelopathy would not resolve. (Exhibit 108).

Dr. Mawk concluded that claimant's cervical problem was really C6-7 disc herniation, and on March 4, 1996, Dr. Mawk proceeded with an anterior cervical discectomy at C6-7 without fusion. (Exhibit 111).

One month after surgery, claimant reported that the numbness and tingling in her right hand had completely resolved. (Exhibit 113). Approximately six weeks after the surgery, Dr. Long reported that claimant was delighted with her improvement after surgery. He observed that claimant's improvement over the previous six weeks was the most marked improvement he had seen in claimant in the past three years. He felt that the dramatic reduction in sensory disturbance in the right hand confirmed that claimant's primary problem was the cervical spine. (Exhibit 115). Two months after the surgery, claimant reported that the aching in her right arm had significantly improved since the previous month. (Exhibit 113).

At the director's request, Dr. Silver reviewed Dr. Long's January 1996 reports and Dr. Mawk's operative report of March 1996. He felt the surgery performed by Dr. Mawk was not appropriate since there was no objective confirmation of compression of either the cervical cord or the C7 nerve root, nor objective confirmation of Dr. Mawk's operative findings. (Ex. 117).

On May 15, 1996, MRU issued an order finding that the March 4, 1996 surgery was not appropriate. (Exhibit 118). By May 1996, claimant's neck and right upper extremity symptoms had significantly improved compared to before the March 1996 surgery. Claimant's head was no longer tilted to the right, the numbness and tingling in her right hand and arm had substantially reduced while strength had increased, and her neck muscles no longer felt inflamed and tight. (Exhibit 119). Claimant's physical therapist also noted substantial physical improvement since the surgery. (Exhibits 119, 120).

When Dr. Long re-checked claimant in June 1996, he reported that she was making "very nice progress." She had virtually no cervical discomfort, but she still had some pain over the right shoulder. (Exhibit 128).

On May 24, 1996, claimant requested reconsideration of the MRU order. (Exhibit 123). The MRU granted the request for reconsideration. (Exhibit 124). MRU allowed claimant to submit additional evidence, including recent reports from Drs. Mawk and Long, as well as claimant's May 1996 affidavit. (Exhibit 13 1). After completing the reconsideration, MRU issued an order on August 30, 1996, affirming its previous order finding that the surgery was inappropriate. (Exhibit 132). Claimant requested a contested case hearing.

Subsequent to MRU's reconsidered order, Drs. Mawk and Long provided additional reasoning in support of the C6-7 cervical surgery. Claimant did not testify at the hearing.

CONCLUSIONS OF LAW AND REASONING

Claimant filed exceptions in response to Judge Upite's

order of December 23, 1996. The exceptions raised by claimant were as follows: 1) Judge Upite misconstrued the issue as "reasonable and necessary" instead of "appropriate"; 2) the procedures established by ORS 656.327 are unconstitutional; 3) MRU was making medical decisions; and 4) MRUs decision did not comport with *Armstrong v. Asten-Hill Co.*, 90 Or App 200 (1988). These exceptions are addressed individually below.

Issue Raised at Hearing

Contrary to claimant's argument, whether Judge Upite characterized claimant's arguments as "reasonable and necessary" or "appropriate" does not change the analysis of this issue The issue of whether surgery is appropriate is controlled by ORS 656.327, which states in relevant part,

> "(1)(a) If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment *** that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties."

In analyzing this matter, Judge Upite utilized this statute with the substantial evidence standard of review. Id. at 2. Thus, the issue was analyzed properly.

Constitutionality of ORS 656.327

Next, claimant argued that the procedures set forth in ORS 656.327 for resolution of medical treatment disputes are unconstitutional. The director previously addressed this issue in *Benney L. Stedham*, I WCSR 147(1996) *affirmed and adopted by* Final Order, I WCSR 402 (1996). The director held that due process rights are protected by "notice, a meaningful opportunity to be heard and an informed and impartial decision***[.]" *Id.* at 150.

Here, although claimant can not cross-examine physicians at the MRU administrative review process, claimant does have the opportunity to submit information, including medical records, affidavits, and legal argument into the written record. OAR 436-010-0008(8). In addition, at the contested case proceeding, OAR 436-001-0195 provides that the following information does not constitute "new medical evidence" and, if relevant, shall be admitted:

> "(1) Supplemental cross-examination of medical professionals whose reports or work products are included in the medical evidence gathered by the director's staff provided the scope of the cross-examination deals with events occurring on or before the date the director's record was closed.
> "(2) Supplemental reports, corrections and clarifications by medical professionals whose reports or work products are in the medical evidence gathered by the director's staff provided the scope of the additional items deals with events occurring on or before the date the director's record was closed."

The rule also permits relevant testimony by the injured

worker. OAR 436-001-0195(4).

Moreover, the statute governing physician reviewers is clear that the physician reviewer's findings and communications are privileged "in any proceeding **other than** those proceedings under this chapter." ORS 656.327(4) (emphasis added); OAR 436-010-0330(4). Similarly, the statute protects physician reviewers from examination **except** in proceedings under ORS Chapter 656. *Id.* Therefore, claimant clearly had a right to cross-examine Dr. Silver; however, she failed to exercise that right by failing to subpoena Dr. Silver. Claimant cannot complain about a lack of cross-examination when procedures exist that allow cross-examination, but claimant failed to use them. *Yvonne French*, I WCSR 764 (1996); *Matthew v. Juras*, 16 Or App 524, 533 (1974); see also *Felling v. Motor Vehicles Division*, 30 Or App 479 (1977); *Richardson v. Perales*, 402 U.S. 389, 404-405, 91 S.Ct. 1420, 1429, 28 L.Ed.2d 842 (1971).

Claimant relied on *Neher v. Chartier*, 319 Or 417 (1994), which found a statute unconstitutional because the plaintiff was left without a remedy. However, *Neher*, *supra*, is distinguishable from this matter because claimant has a remedy. Moreover, the director has held that ORS 656.327 is not unconstitutional because claimant has notice, a meaningful opportunity to participate and an informed and impartial decision maker. Thus, the statute is not unconstitutional.

Whether the Medical Reviewer Was Practicing Medicine

Claimant contends that the medical reviewer who issued the MRU order on behalf of the director, and who is a registered nurse, was practicing medicine without a license by issuing the order. Through ORS 656.327(2), the legislature

gave the director jurisdiction to review medical disputes. MRU's decisions are based on the record, which includes medical opinions. Resolving medical disputes does not constitute the practice of medicine.

Moreover, ORS 677.085 describes what conduct constitutes the practice of medicine. A person is practicing medicine if the person advertises or holds out to the public that he or she is authorized to practice medicine in this state; if the person offers or undertakes to prescribe, give, or administer any drug or medicine for the use of any other person; offers to undertake or perform any surgical operation upon any person; or if the person uses the letters M.D. or D.O. or the title "Doctor," "Physician," or "Surgeon." ORS 677.085 (1), (2), (3), (5). Certainly the medical reviewer did none of these things.

The statute also provides that a person is practicing medicine if the person offers or undertakes to "diagnose, cure or treat in any manner *** any disease, illness, pain, wound, fracture, infirmity, deformity, defect or abnormal physical or mental condition of any person." ORS 677.085(4). It is apparent that the medical reviewer did not offer or undertake to cure or diagnose or treat any condition of claimant. She simply determined what medical treatment was reimbursable by the insurer.[1]

She did not, of course, determine what treatment would actually be rendered; claimant did have the surgery.

Considering the process contemplated by ORS

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[1] She did not, of course, determine what treatment would actually be rendered; claimant did have the surgery.

656.327 and the statutory definition of practicing medicine, I conclude that the medical reviewer was not practicing medicine when she issued the order in this matter.

Sufficiency of the Administrative Order

Claimant contends that the MRU order was inadequate and failed to meet the requirements of *Armstrong v. Asten-Hill Co.*, 90 Or App 200 (1988).

Armstrong requires that an order contain explicit findings of fact and set forth a reasoned explanation of the conclusions drawn from those facts. *Armstrong*, *supra*, 90 Or App at 205, 206. In this case, the MRU order contains extensive findings of fact, covering much of the history of claimant's treatment since her injury. Certainly some of these "findings of fact" are actually more recitations of the evidence than actual findings. Nevertheless, the "conclusion and opinion" portion of the order does explain which medical testimony was accepted and why. The conclusion and opinion portion states that the October 1995 MRI did not show evidence that the C6-7 annulus bulge impinged on the spinal cord or exiting C7 nerve roots. The conclusion further states that there was no evidence of neural involvement and no atypical objective neurological findings. It is further apparent from the conclusion and opinion portion of the order that the medical reviewer found the opinions of Drs. Williams, Marble, and Silver to be more persuasive than the opinions of Drs. Mawk, Long and Schader.

Accordingly, I conclude that, since MRU's order adequately explains its findings and reasoning, the MRU order is sufficient for review.

Substantial Evidence

The question now becomes whether there is any basis to reverse the MRU order. In other words, the question is whether MRU's order contains an error of law or is not supported by substantial evidence. ORS 656.327(2).

Substantial Evidence

As discussed above, this forum has adopted the "substantial evidence" standard set forth in *Armstrong*. I will, therefore, apply the substantial evidence standard and:

> "look at the whole record with respect to the issue being decided, rather than one piece of evidence in isolation. If an agency's finding is reasonable, keeping in mind the evidence against the finding as well as the evidence supporting it, there is substantial evidence. * * * For instance, and in the context which is likely frequently to occur in workers' compensation cases, if there are doctors on both sides of a medical issue, whichever way the [director] finds the facts will probably have substantial evidentiary support. [The Hearings Judge] would not need to choose sides.
>
> The difference between the 'any evidence' rule and the substantial evidence test * * * will be decisive only when the credible evidence apparently weighs overwhelmingly in favor of the finding and the [director] finds the other without giving a persuasive explanation." *Armstrong*, *supra*, 90 Or App at 206.

Claimant argues that the MRU order is not supported by substantial evidence because MRU did not give appropriate

deference to the opinion of the treating physicians. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). I agree with claimant that *Weiland, supra*, applies at the administrative review level. It is a well-established principle of workers' compensation law that deference is given to the attending physician, absent persuasive reasons to do otherwise. This substantive law must be applied during the administrative review process because that type of weighing is not permissible at either the contested case hearing or upon judicial review.

Here, I believe MRU applied the *Weiland* standard, although the reviewer did not so state in specific terms. Although a disc protrusion existed at C6-7 and C7-T1, there was neither diagnostic nor objective clinical evidence of neurological abnormalities. Notwithstanding the tests, Drs. Long and Mawk recommended surgery. However, Paul Williams, M.D., Michael Marble, M.D., and David Silver, M.D. believed surgery was not appropriate. Drs. Williams and Marble concluded that the proposed surgery would not improve claimant's pain complaints, because no objective findings documented cervical radiculopathy. (Ex. 93). They also felt that "functional factors or secondary gain" were involved. (Exhibit 93-5). Dr. Silver stated that claimant's symptoms were relatively non-specific. Without objective evidence of cervical nerve root compression or instability, Dr. Silver recommended disapproval of the surgery. (Exhibit 105-6, 7). Since the clinical and diagnostic evidence supported the opinion of Drs. Williams, Marble and Silver, the record contained persuasive reasons to not defer to the attending physician. Therefore, MRU's order did not contain errors of law. For the same reasons, MRU's order was supported by substantial evidence, I have no authority to modify it.

ORDER

IT IS HEREBY ORDERED THAT MRU's order of August 30,1996 is affirmed.

DATED this 3rd day of April, 1997.

KERRY BARNETT, DIRECTOR
DEPARTMENT OF CONSUMER
AND BUSINESS SERVICES

By: /s/ Mary Neidig
Mary Neidig, Administrator
Workers' Compensation Division

App. C

IN THE SUPREME COURT OF THE STATE OF OREGON

JANICE C. BIAMONT,	)	Agency No. H96-217
	)	
Petitioner,	)	
Petitioner on Review,	)	SC S45796
	)	CA A97380
v.	)	
	)	
PACIFIC SEAFOOD, SAIF CORPORATION and DEPARTMENT OF CONSUMER and BUSINESS SERVICES,	)	
	)	
Respondents,	)	ORDER DENYING
Respondents on Review	)	REVIEW

The Court has considered the petition for review and ORDERS that it be denied.

Dated this 24th day of November 1998.

/s/ WALLACE P. CARSON JR.
WALLACE P. CARSON JR.
CHIEF JUSTICE

Durham and Riggs, JJ., would allow
Kulongoski, J., not participating

c: Meagan Flynn
David Leon Runner
Mary Hazel Williams

ORS 656.327 provides:

(1)(a) If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties.

(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the Workers' Compensation Board within 30 days after issuance of the order. The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding in the order when the record, reviewed as a whole, would permit a reasonable person to make that finding. The decision of the board is not subject to review by any other court or administrative agency.

(c) The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section.

(2) The director shall review medical information and records regarding the treatment. The director may cause an appropriate medical service provider to perform reasonable and appropriate tests, other than invasive tests, upon the

worker and may examine the worker. Notwithstanding ORS 656.325 (1), the worker may refuse a test without sanction. Review of the medical treatment shall be completed and the director shall issue an order within 60 days of the request for review. The director shall create a documentary record sufficient for purposes of judicial review. If the worker, insurer, self-insured employer or medical service provider is dissatisfied with that order, the dissatisfied party may request a contested case hearing before the director pursuant to ORS 183.310 to 183.550. At the contested case hearing, the administrative order may be modified only if it is not supported by substantial evidence in the record or if it reflects an error of law. No new medical evidence or issues shall be admitted. If the director issues an order declaring medical treatment to be not compensable, the worker is not obligated to pay for such treatment. Review of the director's order shall be by the Court of Appeals pursuant to ORS 183.310 to 183.550.

(3) Upon request of either party, the director may delegate to a physician or a panel of physicians the review of medical treatment under this section. At least one member of any such panel shall be a practitioner of the healing art of the medical service provider whose treatment is being reviewed. No member of any such panel shall be a physician whose treatment is the subject of review. The panel shall be chosen in such manner as the director may prescribe, in consultation with the committee referred to in ORS 656.790. The physician or panel shall submit findings to the director within the time limits as prescribed by the director.

(4) The physician or the panel of physicians and the medical arbiter or panel of medical arbiters appointed pursuant to ORS 656.268 acting pursuant to the authority of the director are agents of the Department of Consumer and Business Services and are subject to the provisions of ORS

30.260 to 30.300. The findings of the physician or panel of physicians, the medical arbiter or panel of medical arbiters, all of the records and all communications to or before a panel or arbiter are privileged and are not discoverable or admissible in any proceeding other than those proceedings under this chapter. No member of a panel or a medical arbiter shall be examined or subject to administrative or civil liability regarding participation in or the findings of the panel or medical arbiter or any matter before the panel or medical arbiter other than in proceedings under this chapter.

(5) The costs of review of medical treatment by the physician or panel of physicians pursuant to this section and costs incurred by the worker in attending any examination required under this section, including child care, transportation, lodging and meals, shall be paid by the insurer or self-insured employer.